Deputy Sheriff

2006 Summary of Material Modification

King County
Benefits and Retirement Operations

This Summary of Material Modification (SMM) describes changes to information in "Your King County Benefits," the collection of booklets describing coverage available to you under the King County deputy sheriff benefit plans:

- *Red italic changes* became effective *in 2005*, unless otherwise noted
- **Red bold changes with an underline** become effective ***January 1, 2006***, unless otherwise noted.

Please refer to this and subsequent SMMs provided each year at open enrollment for updates to "Your King County Benefits." The collection of plan booklets and a copy of this SMM are available on the Internet (www.metrokc.gov/employees/benefits), in the county e-mail system public folders (Public Folders\Finance\ Benefits and Retirement) and from Benefits and Retirement Operations.

Questions? Contact Benefits and Retirement Operations at:

- Exchange Building EXC-ES-0300, 821 Second Ave., Seattle WA 98104
- kc.benefits@metrokc.gov
- 206-684-1556.

This Summary of Material Modification (SMM) describes the changes that affect your benefit plans and updates your plan descriptions. SMMs together with the plan booklets make up your official plan descriptions; please keep them together and refer to them as necessary. We've made every attempt to insure the accuracy of the information in this SMM and the plan booklets. *However, if there is a dispute or discrepancy with benefits, the wording of the Benefit Booklet will prevail.*

Call 206-684-1556 for alternate formats.

Booklet 1

Important Facts

When Coverage Begins (page 9)

► When Coverage Begins for You

Coverage begins the first of the month following your hire date, as determined by the Sheriff's Office. If your hire date is the first of the month, your coverage begins the same day.

When you change coverage during open enrollment, your new coverage begins January 1 of the following year and stays in effect for the entire calendar year, as long as you remain eligible.

When you're first eligible, the start of some coverage may be delayed:

- Medical/Vision. If you're hospitalized *on the day coverage would start, your coverage will begin on the effective day of the new plan, even though your hospital stay may be covered by your prior carrier.*
- Life. If you're not actively at work on the day coverage would start because of illness or injury, coverage begins on your first full day back at work.
- AD&D. If you're not regularly performing the duties of your occupation on the date coverage would start, coverage begins on the first day of the month following your return to those duties.

Changes You May Make When a Qualifying Event Occurs

Addition of one subsection at the beginning and a change to another subsection.

► You May Change Your Health Plan (page 11)

New special enrollment rights under the Health Insurance Portability and Accountability Act (HIPAA) allow you and your eligible dependents to change to another medical plan benefit option offered at your workplace at the time of a qualifying event – provided you are receiving your medical coverage as an active employee or under COBRA, not under retiree medical.

Thus, upon the occurrence of a qualifying event, you and all of your eligible dependents may either:

- **Enroll in your current medical coverage, or**
- **Enroll in any medical plan benefit option for which you and your dependents are eligible.**

Before the new special enrollment rights, you could only add new family members to your existing medical coverage and make changes to life insurance coverage.

The new special enrollment rights also allow you to change to another medical plan benefit option offered at your workplace when you reach the lifetime maximum for your medical benefits under your existing medical coverage option.

► You May Add Eligible Family Members for Health Coverage (page 11)

Except for birth or placement for adoption, you must submit an Add New Family Member form within 30 days of these qualifying events (sooner if possible) to add an eligible family member for health coverage (medical/vision and dental):

- Placement of a legal ward
- Marriage or establishment of a domestic partnership
- Significant change in your spouse/domestic partner's employer-sponsored coverage.

If you do not submit the form within 30 days, you must wait until the next open enrollment to add the eligible family member for coverage.

Birth or Placement for Adoption. A newborn is automatically covered under the mother's coverage for the first 21 days. You have 60 days to add a newborn or a newly adopted child for health coverage. If you do not submit the form within 60 days, *if additional premium is due to provide coverage*, you *then* must wait until the next open enrollment to add the eligible family member for coverage.

Qualified Medical Child Support Order. When Benefits and Retirement Operations receives a QMCSO, the child is automatically added for coverage according to the terms of the document (you do not need to submit an Add New Family Member form).

COBRA (pages 21-23)

Changes and additions throughout the section. The administrator of COBRA remains the same, but the administrator name changes from Associated Administrators, Inc. (AAI) to Personal Choice Account offered by Regence BlueCross and BlueShield of Oregon, referenced as PCA. (16 references).

► *COBRA Eligibility*

If you lose your health plan coverage through the county, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) gives you (the employee or the employee's family member) the right to continuation of coverage when you would otherwise lose it. A notice describing COBRA rights is mailed to your home within 30 days after you first enroll for your county coverage.

COBRA continuation coverage is a continuation of health plan coverage when coverage would otherwise end because of a life event known as a qualifying event. After a qualifying event, COBRA continuation coverage must be offered to each person who is a qualified beneficiary. You, your covered spouse, your covered domestic partner and your covered dependent children could become qualified beneficiaries if coverage under county health plans is lost because of a qualifying event.

► *COBRA Qualifying Events*

Employee. If you're an employee, you become a qualified beneficiary if you lose coverage under your King County health plans due to any of these qualifying events:

- *A change in your job status, such as a reduction in hours, causes you to lose coverage*
- *Your employment ends for any reason other than your gross misconduct.*

Spouse/Domestic Partner. If you're the covered spouse/domestic partner of an employee, you become a qualified beneficiary if you lose coverage under your King County health plans due to any of these qualifying events:

- *Your spouse/domestic partner dies*
- *A change in your spouse's or domestic partner's job status, such as a reduction in hours, causes you to lose coverage*
- *Your spouse's/domestic partner's employment ends for any reason other than his or her gross misconduct*
- *You divorce from your spouse (legal separation is not a qualifying event) or end your domestic partnership.*

[Reference to Medicare benefits as a qualifying event deleted]

If you're the covered spouse dropped from coverage by the employee in anticipation of a divorce and a divorce later occurs, then the divorce is considered the qualifying event even though you lost coverage earlier. Contact Benefits and Retirement Operations within 60 days after the divorce with documentation of the event. COBRA eligibility begins the first of the month following the divorce. [References to legal separation deleted]

Dependent Children. Your covered dependent children become qualified beneficiaries if they lose coverage under your King County health plans due to any of these qualifying events:

- *Parent-employee dies*
- *A change in your parent-employee's job status, such as a reduction in hours, causes you to lose coverage*
- *Parent-employee's employment ends for any reason other than his or her gross misconduct*
- *Parents divorce (legal separation is not a qualifying event) or end their domestic partnership*
- *Child stops being eligible for coverage under the plan as a "dependent child."*

[Reference to Medicare benefits as a qualifying event deleted]

► *COBRA Plan Options and Cost*

Under the county health plans, qualified beneficiaries who elect COBRA continuation must pay for COBRA continuation coverage. Your plan options and the cost are explained in information you receive from PCA, the county's COBRA administrator, when you qualify for COBRA. They include:

- *Medical/vision only*
- *Dental only (if you're a LEOFF 1 retiree).*

To continue coverage under COBRA, you must be covered under the plan on your last day of employment. For example, to continue medical/vision, you must have medical on your last day; you can't continue medical/vision if you don't have it.

You may continue covering the same family members who were covered the last day of your employment. Each family member has an independent right to elect continuation coverage. For example, both you and your spouse may elect continuation coverage, or only one of you may elect the coverage. Parents may elect to continue coverage on behalf of their dependent children only.

You and/or your qualified family members may continue Medicare or another group health plan, if the effective date is before the COBRA election date.

If you are participating in a Health Care Flexible Spending Account when you become eligible for COBRA, you may continue participating through the end of the calendar year as long as you meet the requirements (see the Flexible Spending Accounts booklet).

Life Insurance. It is not a provision of COBRA, but if you end employment with the county (not if you leave employment due to a disability), you may be eligible to continue your life insurance coverage through the portability feature of the policy (see the Aetna Life Insurance booklet for additional details on portability or converting your coverage).

► *Reporting COBRA Qualifying Events*

COBRA qualifying events of termination, change in job status or employee death are reported to Benefits and Retirement Operations through the employee's termination notice or payroll report.

For the other qualifying events (divorce of employee and spouse, end of domestic partnership or a dependent child's loss of eligibility for coverage as a dependent child), you (employee or family member) must submit a Delete Family Member form to Benefits and Retirement Operations within 60 days of the last day of the month the qualifying event occurs or the date coverage ends, if later. The form is available from Benefits and Retirement Operations (see Resource Directory booklet). [Reference to legal separation deleted]

You can fax, mail, e-mail or hand-deliver the form to Benefits and Retirement Operations, but oral notice (including notice by telephone) is not acceptable.

If these procedures are not followed or if a Delete Family Member form is not received by the last day of the 60-day notice period (if mailed, it must be postmarked by the last day of the 60-day notice period), any spouse, domestic partner or dependent child who loses coverage will not be offered the option to elect COBRA continuation coverage.

► *COBRA Enrollment*

When COBRA-qualifying information is received, Benefits and Retirement Operations notifies PCA, the county's COBRA administrator, and PCA offers COBRA continuation coverage to each qualified beneficiary, explaining COBRA plan options and cost. Each qualified beneficiary has an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses or domestic partners, and parents may elect COBRA continuation coverage on behalf of their children.

You have 60 days after coverage ends to make your COBRA elections or 60 days from the date of the *qualifying event notice sent by PCA, whichever is later. You or your qualified family members may change a prior rejection of continuation coverage any time until that date by submitting a written request to PCA . Failure to elect coverage within 60 days will result in loss of the right to elect continuation coverage.*

If you elect COBRA continuation coverage, you must make the initial *premium* payment by the 45th day after electing it. *If you do not remit payment with your election form within the initial 45 days, your coverage will be suspended and then retroactively reinstated back to the loss of coverage under the employer's plan. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.* The amount you or your qualified family member may be required to pay may not exceed 102 percent of the cost of the county's plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage (or, in the case of an extension of continuation coverage due to a disability, 150 percent). Thereafter, all premiums are due the first of the month; coverage automatically ends if payment is not made within 30 days. *PCA* will provide you with more detailed payment information.

Once you have elected COBRA and paid the premium, COBRA continuation coverage is retroactive *to the first day of the month in which your coverage ended.* There is no lapse in coverage – self-paid benefits begin when county-paid benefits end, even if retroactive processing and payments are required. Your initial payment must include all applicable back premiums.

► *Length of COBRA Continuation Coverage*

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, divorce, end of domestic partnership or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. [Reference to entitlement to Medicare benefits and reference to legal separation deleted]

If the covered employee's Medicare entitlement precedes a termination or reduction in hours of employment, then the employee's spouse and dependent children, if any, are entitled to COBRA coverage for up to the greater of 18 months from the termination of employment or 36 months from the earlier Medicare entitlement date.

For example, if a covered employee becomes entitled to Medicare eight months before the date on which his/her employment ends, COBRA continuation coverage for the employee's spouse or domestic partner and children can last up to 28 months after the date of the qualifying event (36 months minus eight months).

Otherwise, when the qualifying event is the end of employment or a change in the employee's job status where there is a loss of coverage, COBRA continuation coverage lasts up to a total of only 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension of 18-Month Period of Continuation Coverage. An 11-month extension of coverage may be available if any of the qualified beneficiaries is disabled. The Social Security Administration (SSA) must determine that the qualified beneficiary was disabled at some time during the first 60 days of continuation coverage, and you must notify PCA in writing of that fact within 60 days of the SSA's determination and before the end of the first 18 months of continuation coverage. All of the qualified beneficiaries who have elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify PCA in writing of that fact within 30 days of SSA's determination.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage. If your family experiences another qualifying event while receiving 18 or 29 months of COBRA continuation coverage, the spouse or domestic partner and dependent children in your family can get additional months of COBRA continuation coverage, for a total maximum of 36 months from the date when COBRA coverage began, if notice of the second qualifying event is properly given to the plan. This extension may be available to the spouse or domestic partner and any dependent children receiving continuation coverage if the employee or former employee dies, divorces, ends a domestic partnership, or if the dependent child stops being eligible under the plan as a dependent child, but only if the event would have caused the spouse, domestic partner or dependent child to lose coverage under the plan had the first qualifying event not occurred. [References to legal separation deleted]

► Making Changes under COBRA

If you notify *PCA* (King County's COBRA administrator), you may:

- Drop dental and vision and retain medical coverage anytime (notice must be received by *PCA* in the month before you want the change to become effective)
- Drop yourself and family members from coverage anytime (notice must be received by *PCA* in the month before you want the change to become effective)
- Add new eligible family members to your health coverage when a qualified change in status occurs (see "Changes You May Make When a Qualifying Event Occurs" in this booklet)
- Change medical plans during open enrollment
- Change medical plans between open enrollments if you move out of your current plan's coverage area and provide proof of your new permanent address, and another King County plan offers coverage in your new location.

► When COBRA Coverage Ends

Continuation coverage will be terminated before the end of the maximum period if:

- *Any required premium is not paid on time*
- *A qualified beneficiary becomes covered under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary*
- *A covered employee enrolls in Medicare*
- *The employer ceases to provide any group health plan for its employees*
- *For any reason the plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud)*
- The plan terminates *(whether by contract or county bankruptcy)* or you first become covered under another group health plan after the date of your COBRA election (unless the plan limits or excludes coverage for a preexisting condition of the individual continuing coverage).

If you die, your covered family members may extend their COBRA coverage up to 36 months from the date their COBRA coverage started.

The Health Insurance Portability and Accountability Act (HIPAA) restricts the extent group health plans may impose preexisting condition limits:

- If you become covered by another group *health* plan and that plan contains a preexisting condition limit that affects you, your COBRA continuation coverage cannot be terminated. However, if the other plan's preexisting rule doesn't apply to you, your COBRA continuation coverage will be terminated.
- You do not have to show you are insurable to choose COBRA continuation coverage. However, COBRA continuation coverage is subject to your eligibility for coverage; King County reserves the right to terminate your coverage retroactively if you are determined ineligible.

You may be entitled to purchase an individual conversion policy when you are no longer covered under the county's plan. An individual conversion policy usually provides different coverage from your group coverage; some benefits you have now may not be available. Also, a conversion policy may cost more than your current coverage.

► For More Information

More information regarding your rights to continuation coverage is available from *PCA* or Benefits and Retirement Operations (see Resource Directory booklet). For more information about COBRA, the Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting group health plans, *contact the nearest regional or district office of the U.S. Department of Labor's Employee Benefits Security Administration (ESBA). Addresses and phone numbers for the nearest regional or district offices are available at www.dol.gov/ebsa.*

► Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep King County and *PCA* informed of any changes in addresses of family members. You should also keep copies for your records of any address change notices you send the county or *PCA*.

Retiree Benefits

Changes to two subsections. The administrator of retiree benefits remains the same, but the administrator name changes from Associated Administrators, Inc. (AAI) to Personal Choice Account offered by Regence BlueCross and BlueShield of Oregon, referenced as PCA. (5 references).

► Retiree Benefit Eligibility (page 18)

County-paid coverage ends the last day of the month you retire. You may self-pay to continue medical/vision coverage (but not dental) if you:

- Have county benefits on your last day of employment
- Have worked for King County for at least five consecutive years before you retire
- Are not eligible for Medicare (unless you're enrolled in Group Health)
- Are not covered under another medical/vision group plan, *and*
- Meet the requirements for formal service or disability retirement under the Washington State Public Employees Retirement Act or the City of Seattle Retirement Plan (which applies only if you elected to remain under the City of Seattle system according to a formal agreement between King County and the City of Seattle). *[This change has been added to clarify how your benefits are administered.]*

However, there is an exception. You are not eligible to self-pay under retiree medical if you:

- *Are an employee with a spouse/domestic partner who is also a county employee, and*
- *Have opted out of your own coverage to be covered under your spouse's/domestic partner's county coverage (this means your coverage is in your spouse's/domestic partner's name, not your own), and*
- *Retire before your spouse/domestic partner does.*

Your county health coverage must be in your name at the time of your retirement for you to be eligible for retiree medical. However, you may continue your coverage under your spouse's/domestic partner's county health benefits. [This change has been added to clarify how your benefits are administered.]

Covered family members are eligible for continued coverage under your retiree benefits if they're not eligible for Medicare and meet the same eligibility requirements in effect when you were an active employee. Dental, life and AD&D coverage is not available under retiree benefits.

Retiree benefits are an alternative to COBRA; if you elect retiree benefits, you waive your COBRA rights. Consider these differences in choosing between retiree and COBRA benefits:

	Retiree Benefits	COBRA
Health coverage available	Medical/vision	Medical/vision and dental
Length of time coverage available	Generally, until you become eligible for Medicare (Group Health offers coverage for those eligible for Medicare)	18 months maximum (29 months if you leave employment due to a Social Security verified disability)
Allowed to change medical/vision plans between open enrollments	No	Yes, if you relocate out of your current plan's coverage area and notify *PCA* with proof of your new permanent address and availability of coverage under another King County plan in your new location

If you're participating in a Health Care Flexible Spending Account when you become eligible for retiree benefits or COBRA, you may continue participating through the end of the calendar year (see the Flexible Spending Accounts booklet).

► If You Lose Eligibility for Retiree Benefits Due to Medicare *Entitlement* (page 20)

If you retire and elect retiree benefits for you and your qualified family members before you become entitled to Medicare, the retiree benefits end for everyone when you become Medicare entitled. When this occurs:

- *You may apply for Medicare supplemental insurance for yourself through PCA. The supplemental insurance is provided through the PacifiCare Secure Horizons plan. To qualify, you must contact PCA and apply within 30 days of when your retiree benefit coverage ends.*
- *Your family members may continue their county benefits coverage under COBRA for up to 36 months from the date of your Medicare entitlement – PCA will notify them of this option by sending a COBRA qualifying event notice with an election form to be returned to PCA to enroll the family members. (COBRA may provide a longer period of continuation coverage for qualified family members than retiree benefits, based on the date you retire and the date you become Medicare entitled. For more information, contact Benefits and Retirement Operations.)*

If you retire when or after you become entitled to Medicare, you and your family members are not eligible for retiree benefits but:

- *You may apply for Medicare supplemental insurance for yourself through PCA, as described in the previous paragraph.*
- *Your qualified family members may continue county benefit coverage under the provisions of COBRA (for up to 36 months from the date of your Medicare entitlement).*

Booklet 2

Regence BlueShield Medical/Vision

How the Plan Works

Changes to one subsection, two subsections deleted and one subsection renamed.

► Annual Out-of-Pocket Maximum (page 31)

The out-of-pocket maximum is the most you pay in coinsurance for covered expenses each plan year. This means once you reach your out-of-pocket maximum, the plan pays 100% of most covered expenses for the rest of the calendar year.

Your annual out-of-pocket maximum is $375 per person. The following do not apply to the out-of-pocket maximum:

- Annual deductible
- Charges in excess of allowed amounts
- Charges beyond benefit maximums and limits
- Copays for emergency room care or prescription drugs
- Expenses not covered by the plan
- Services for:
  - Neurodevelopmental therapy
  - **Outpatient mental health care – This service now applies to the out-of-pocket maximum to conform with the requirements of the Washington State Mental Health Parity Law (see Mental Health under "Covered Expenses Under Regence BlueShield")**
  - Outpatient rehabilitation
  - Smoking cessation
  - Tooth repair
- The amount you pay for inpatient care outside the service area from a non-participating provider if it's not approved by Regence BlueShield.
- *[This bullet reference deleted: "The amount you pay if you're a LEOFF 2 member and:*
  - *Certain surgeries are performed on an inpatient basis (see "Mandatory Outpatient Surgery for LEOFF 2 Members Only")*
  - *You don't obtain a mandatory second surgical opinion (see "Mandatory Second Surgical Opinions for LEOFF 2 Members Only"). "]*

► Mandatory Outpatient Surgery for LEOFF 2 Members Only (page 33)

Subsection deleted.

► Mandatory Second Surgical Opinions for LEOFF 2 Members Only (page 34)

Subsection deleted.

► *Voluntary Second Surgical Opinions (page 35)*

If you choose to get a second opinion before having surgery, the physician's services and any related x-ray and lab charges are paid in full for the second opinion. They're not subject to the annual deductible when performed by the physician referred to you as described in this section.

Your participating physician can obtain a second opinion referral by contacting Regence BlueShield. The second opinion must be obtained from a physician referred by Regence BlueShield who will not be performing the surgery.

If you don't follow the second opinion procedures, benefits will be paid at the payment level described for "Professional Services" in the "Summary of Covered Expenses" section, subject to the deductible.

A third opinion is covered if the first two opinions do not agree, but no additional opinions are covered. Once you receive the second opinion, even if the physicians don't agree, the decision to have the surgery rests with you.

Covered Expenses Under Regence BlueShield

Changes to nine subsections.

► Summary of Covered Expenses (pages 35-37)

There are several changes to benefits described in the summary table:
- *Chemical dependency (page 36) – Maximum increases from $12,500 in 2005 to* **$13,000** *in 2006*
- *Injury to teeth (page 36) – 80% up to $1,000/injury.*

► Chemical Dependency Treatment (page 38)

The services and supplies of **a chemical dependency treatment program [reference to "an approved program" deleted]** are covered, including supportive services. **Medically necessary detoxification will be covered as a medical emergency and expenses incurred will not accrue to the $13,000 two-year calendar maximum, described in the summary table (see page 36), if the member is not enrolled in other chemical dependency treatment.** Expenses for:
- Acupuncture related to chemical dependency treatment count toward the maximum, but not the regular 12 visit/calendar year acupuncture benefit.
- Medically necessary detoxification are covered as emergency care and do not count toward the maximum benefit if you're not enrolled in other chemical dependency treatment.
- Drugs prescribed and dispensed through an approved chemical dependency treatment facility are covered and count toward the maximum benefit.

Except for medically necessary detoxification, the program must submit treatment notice at least 10 days before treatment begins, whenever reasonably possible. When you're under court order to undergo chemical dependency assessment (or in other situations pending legal actions related to chemical dependency), Regence BlueShield reserves the right to require you, at your expense, to provide a chemical dependency treatment plan and initial chemical dependency assessment performed by **a chemical dependency treatment program [reference to "a qualified counselor employed by an approved program" deleted]** at least 10 days before treatment begins.

(For benefit, "medically necessary" is defined by "Patient Placement Criteria for the Treatment of Substance Abuse-Related Disorders II," published in 1996 by the American Society of Addiction Medicine.)

Chemical dependency benefits exclude:
- Alcoholics Anonymous or similar chemical dependency programs
- Emergency service patrol
- Information or referral services
- Information schools
- Long-term care or custodial care
- Tobacco cessation programs or supplies (except as described under "Smoking Cessation").

No other chemical dependency benefits are provided under this plan, except as described above for detoxification. *However, additional counseling and referral services are available through King County's Making Life Easier Program by calling 1-888-874-7290.*

► Home Health Care (pages 39-40)

The services and supplies of **a home health care agency** **[reference to "an approved home health care agency" deleted]** are covered in your home for treatment of an illness or injury if you meet all of these criteria:

- You're homebound – which means that leaving the home could be harmful, involving a considerable and taxing effort – and unable to use transportation without **the** assistance **of another**
- Your condition is serious enough to require confinement in a hospital or skilled nursing facility in the absence of home health services.
- *[This bullet reference deleted: "Your provider establishes or approves a written treatment plan specifying home health services and supplies (plan must be approved by Regence BlueShield)."]*

Home health care benefits may be extended beyond the 130-visit per year maximum if you apply to Regence BlueShield and the plan determines continued treatment is medically necessary. Any home health care expenses that qualify under this benefit and under another benefit of this plan will be covered only under the benefit Regence BlueShield determines most appropriate.

Benefits are limited to the following services in your home and must be provided by employees of and billed by the home health agency:

- Home health aide services, including such care as:
  - Ambulation and exercise
  - Assistance with self-administered medications
  - Completing appropriate records
  - Personal care or household services that are needed to achieve the medically desired results
  - Reporting changes in your condition and needs
- Medical supplies dispensed by the home health care agency that would have been provided on an inpatient basis
- **Skilled services [reference to "by approved providers" deleted], including**:
  - Medical social services
  - Intermittent skilled nursing services
  - Physical, occupational, respiratory and speech therapy services
- **Nutritional guidance [Removed from previous bullet reference: "Skilled services"].**

For professional services, home medical equipment and infusion therapy see those sections.

Home health care benefits exclude:

- Custodial or maintenance care
- Financial or legal counseling services
- Food, clothing, housing or transportation (except as described **in "Ambulance Services"**)
- Homemaker or housekeeping services (except as **specifically provided under "Home Health Care"**)
- Hourly care services
- Services normally provided under a hospice program
- Services of volunteers, household members, family or friends
- Services or supplies not specified as a covered benefit **[reference to "in the written treatment plan" deleted]** or limited or excluded under the **regular limitations of this plan**
- Services to other family members
- Supportive environmental materials, such as but not limited to ramps, handrails or air conditioners.

► Hospice Care (pages 40-41)

Hospice care is a coordinated program of supportive care for a dying person by a team of professionals and volunteers. Services of **a hospice [reference to "an approved hospice" deleted]** are covered for medically necessary treatment or palliative care (relief of pain and other symptoms) if:

- You're terminally ill
- *[This bullet reference deleted: "Your provider establishes or approves a written treatment plan specifying hospice services and supplies (plan must be approved by Regence BlueShield)."]*

Hospice benefits are limited to six months, but the benefits may be extended beyond the six-month maximum if you apply to Regence BlueShield and the plan determines continued treatment is medically necessary. Any hospice care expenses that qualify under this benefit and under another benefit of this plan will be covered only under the benefit Regence BlueShield determines most appropriate.

Home Care. Benefits are limited to the following services in your home and must be provided by employees of and billed by the hospice:

- Home health aide services **[This parenthetical reference deleted: "(limited to visits of four or more hours when skilled care is required by an RN, LPN or home health aide, up to a combined total of 120 hours for nursing services and home health aide services)"]**, including such care as:
  - Ambulation and exercise
  - Assistance with self-administered medications
  - Completing appropriate records
  - Personal care or household services needed to achieve the medically desired results
  - Reporting changes in your condition and needs
- Medical supplies dispensed by the hospice that would have been provided on an inpatient basis
- Respite care to provide temporary relief to family members or friends providing care (limited to four or more hours a day) **[Reference to "when no skilled care is required up to a combined total of 120 per three-month period" deleted]**
- Medical social services
- Nursing services (limited to visits of four or more hours when skilled care is required by an RN, LPN or home health aide, up to a combined total of 120 hours for nursing services and home health aide services)
- Nutritional guidance
- Physical, occupational, respiratory and speech therapy services.

For professional services, home medical equipment or infusion therapy, see other benefits in this plan.

Inpatient Care. When you're confined as an inpatient in **a hospice [reference to "by an approved hospice" deleted]** that isn't a **hospital [reference to "participating hospital" deleted]** or skilled nursing facility, the same benefits that are available in your home **will be available to you as an inpatient. Room and board is limited to the hospice's average semiprivate room rate, except where a private room is determined to be medically necessary.** The services must be provided by employees of and billed by the **hospice [reference to "participating hospice" deleted].** This inpatient **hospice** benefit is limited to 14 days during the six-month benefit period. **For services in a hospital or skilled nursing facility, see "Hospital/Facility Services" and "Skilled Nursing Facility."**

Limitations. Hospice benefits are limited to a maximum of six months. In addition, hospice benefits have the following limits:

- **Visits of four or more hours in which skilled care is required by a registered nurse, licensed practical nurse or home health aide will be limited to a combined total of 120 hours.**
- **Respite care of four or more hours per day in which no skilled care is required will be limited to a combined total of 120 hours per three-month period.**

- **Any expenses for hospice care that qualify both under this benefit and under any other benefit of this plan will be covered only under the benefit that Regence BlueShield determines to be the most appropriate.**

If the benefit is exhausted, you may apply to Regence BlueShield for an extension of benefits. Limited extensions may be granted if Regence BlueShield determines that the treatment is medically necessary.

Exclusions. Hospice benefits exclude:
- Custodial or maintenance care (except **that** benefits **will be provided** for palliative care to a terminally ill patient, subject to the limits described)
- Financial or legal counseling services
- Food, clothing, housing or transportation (except as described **in "Ambulance Services"**)
- Homemaker or housekeeping services (except as described)
- Services of volunteers, household members, family or friends
- Services or supplies not **specifically set forth** as a covered benefit **[reference to "in the written treatment plan" deleted]**, or limited or excluded under the **regular limitations and exclusions of the** plan
- Services to other family members
- Spiritual or bereavement counseling
- Supportive environmental materials, such as but not limited to ramps, handrails or air conditioners.

► Injury to Teeth (page 42)

Services of a licensed dentist or denturist **[reference to "and related hospital expenses" deleted]** are covered for repair of accidental injury **(trauma)** to **natural teeth that are whole and functionally sound or have been restored to a sound functional capacity. Benefits will be provided for the treatment of the injury for a period of 12 consecutive months from the date of injury to a maximum of $1,000 per occurrence. Services for treatment must begin** within 30 days **from the date** of the injury **in order for any benefits to be payable for repair of teeth. This benefit will not be provided for any injury caused by biting or chewing or for dental implants. No other charges of a dentist or denturist will be covered under this plan**

This benefit is supplemental to your dental plan coverage.

Charges for repair of teeth do not count toward the out-of-pocket maximum.

► Mental Health Care (page 44)

Mental health care is now covered the same as other outpatient medical care, as a result of the Washington State Mental Health Parity Law, but visit limits can remain. The law, which passed in 2005, begins phasing in requirements to place mental health treatments on parity with physical health treatments on January 1, 2006.

Inpatient. Inpatient mental health care is covered to a maximum of eight days per calendar year when you're confined **as an inpatient in an accredited general or psychiatric** hospital, a state mental hospital **as defined in state law**, or a licensed community mental health agency **that has an accredited** inpatient facility.

Partial hospital day treatment at a facility **[reference to "an approved facility" deleted]** counts toward the eight-day inpatient maximum per calendar year; two partial days **or two residential treatment days** will count as one inpatient day. **[Reference to "regardless of partial day duration" deleted]**

Outpatient. Outpatient mental health care is covered **at 100% (formerly 50%)** of the allowed amount of the plan for a maximum of 12 visits per calendar year when received from an approved provider:
- **Physician**
- **Advance registered nurse practitioner**
- Licensed community mental health agency

- **Licensed** marriage and family therapist **(**marriage counseling **will not be covered, and family counseling will only be covered when the identified member is a child or an adolescent with a covered diagnosis and the family counseling is part of the treatment)**
- **Licensed independent clinical social work**
- **Licensed** mental health counselor
- **Psychologist.**

Services that may be covered under this benefit include, but are not limited to:
- **Diagnostic testing for learning disabilities**
- **Mental disorders** related to a self-inflicted injury or attempted suicide
- **Mental disorders** related to an eating disorder (anorexia nervosa, bulimia or any similar condition is covered only for counseling under this benefit)
- **Diagnostic testing and treatment for mental disorders** with a congenital or physical basis.

Coinsurance paid for outpatient care **now applies** to your out-of-pocket maximum.

(You may also receive limited mental health care benefits at no cost through King County's Making Life Easier Program by calling toll-free 1-888-874-7290.)

► Occupational Injury for LEOFF 1 Members Only (page 45)

Services and supplies to treat occupational illness and injury are covered for LEOFF 1 members at 100% of the allowed amount for participating providers and 100% of the billed charges for non-participating providers. *This benefit* is not subject to the annual deductible.

► Rehabilitative Services (pages 48-49)

The benefits described below are for rehabilitative care when medically necessary to restore and improve function previously normal but lost following a documented illness (for example, stroke, viral infection or bacterial infection – prenatal, perinatal, childhood, adolescence or adulthood) or injury (prenatal, perinatal, childhood, adolescence or adulthood), including function lost as a result of congenital anomalies. **All treatment must be prescribed** by a participating provider.

The plan covers:
- Inpatient hospital and skilled nursing facility expenses for physical, speech or occupational therapy to a maximum of $50,000 per condition. Services must be received in a hospital or skilled nursing facility approved by Regence BlueShield for rehabilitative services, and treatment must occur within three years from the date of your first hospital or skilled nursing facility rehabilitative care admission. *[Reference to "At least every 60 days, your provider must submit for approval and review a written treatment plan specifying rehabilitative services before treatment is received, except in emergencies" deleted]*
- Physical, occupational or speech therapy in the office, home or hospital outpatient facility is covered to $2,000 per calendar year **[reference to "if performed by an approved provider" deleted]** for physical, occupational and speech therapy only or a hospital **outpatient department** approved **by Regence BlueShield** for rehabilitative care.

Charges for rehabilitative services do not contribute to the out-of-pocket maximum.

[This paragraph deleted: "If you have a rehabilitative care admission and did not exhaust your $50,000 inpatient maximum, you may apply to Regence BlueShield for additional outpatient benefits beyond the $2,000 limit. Limited extensions will be granted, up to the balance of your unused inpatient benefit, if Regence BlueShield determines the services are medically necessary."]

You're not eligible for the neurodevelopmental therapy benefit if you receive the same services for the same condition under this benefit.

No benefits are provided for:

- Chemical dependency rehabilitative treatment
- Custodial care
- Gym or swim therapy
- Learning disabilities or developmental delay
- Maintenance therapy (treatment to prevent disease, promote health or prolong and enhance life, or maintain/prevent deterioration of a chronic condition; once the maximum therapeutic benefit is achieved for a given condition, any additional therapy is considered to be maintenance therapy)
- Mental **disorder** care
- Non-medical self-help
- Recreational, educational or vocational therapy
- **Any services or supplies specifically excluded under the regular limitations and exclusions of this plan.**
- **[This bullet reference deleted: "Treatment not prescribed by a participating provider."]**

► Skilled Nursing Facility (page 49)

Inpatient services and supplies of an approved skilled nursing facility are covered for illness, accidental injury or physical disability, limited to 90 days per calendar year. Room and board is limited to the facility's average semiprivate room rate, **except where a private room is determined to be medically necessary.** Your **physician [reference to "approved physician" deleted]** must request Regence BlueShield approval and periodically review a written treatment plan specifically describing services to be provided. Custodial care is not covered.

[Additional provisions to receive this benefit deleted.]

Filing a Claim

Changes to one subsection.

► What to Do (page 53)

If you receive care from a participating provider, the provider submits claims for you; if you receive a bill from a provider or facility, be sure they have billed Regence BlueShield. If you receive emergency services from a non-participating provider, it's your responsibility to submit a claim to Regence BlueShield or have the provider submit one for you.

When submitting any claim, you need to include your itemized bill. It should show:

- Patient's name
- Provider's tax ID number
- Diagnosis or ICD-9 code
- Date of service or date of purchase/rental of supplies
- Itemized charges from the provider for the services/supplies received
- **For medical equipment and supplies, also the date of purchase, or beginning and ending dates of rental; supplier's tax identification number; name of referring provider; whether purchase is initial purchase or replacement; and if a replacement, the reason why. A signed authorization from the provider specifying duration of need is required.**

You also need to provide:

- Your name (if you were not the patient)
- Your member ID number
- Group number (shown on your Regence BlueShield ID card and available from Benefits and Retirement Operations)

- Date, time, location and brief description of accident if treatment is the result of an accident.

For prompt payment, submit all claims as soon as possible. The plan will not pay a claim submitted more than *15* months after the date of service or date of purchase/rental of supplies (*six* months if the plan is terminated).

Extension of Coverage (page 58)

If this plan is canceled, Regence BlueShield will continue to cover any participants who are hospital inpatients on the cancellation date. Coverage ends when the first of the following events occurs:

- Six consecutive months expire
- Your hospital/facility inpatient care benefits under the plan are exhausted (no benefits renew January 1)
- You become covered under another group contract with Regence BlueShield
- You're enrolled under a contract with another company that provides hospital inpatient care
- You're discharged from the hospital/facility.

This extension does not apply to the newborn who is eligible for coverage only for the first 21 days following birth as specified in "Newborn Care," nor does it apply if you're eligible for COBRA continuation.

[Maternity and disability extension information deleted.]

Booklet 3

PacifiCare Medical/Vision

Cover of PacifiCare Medical/Vision

On the cover of the PacifiCare Medical/Vision booklet, the following paragraph now reads:

Although these benefit descriptions include certain key features and brief summaries of King County deputy sheriff benefit plans, they are not detailed descriptions. If you have questions about specific plan details, contact the plan or Benefits and Retirement Operations. We've made every attempt to ensure the accuracy of this information. *However, if there is a dispute or discrepancy with benefits, the wording of the Benefit Booklet will prevail.* King County intends to continue benefit plans indefinitely, but reserves the right to amend or terminate them at any time in whole or in part, for any reason, according to the amendment and termination procedures described in the legal documents. King County, as plan administrator, has the sole discretionary authority to determine eligibility for benefits and to construe the terms of the plans. This information does not create a contract of employment between King County and any employee.

How the Plan Works

Changes to three subsections.

► Specialists (page 65)

Your PCP is responsible for determining when it's medically necessary for you to see a specialist, except for visits to obstetrical and gynecological providers (described in this section) and certain specialists as described in the "Accessing Care" section of this booklet. If your PCP determines you need a referral, he/she submits a request to your participating medical group or PacifiCare; then a Utilization Review Committee reviews the request. If approved by the committee, the referral is authorized and may require your specialist to provide your PCP with regular reports on your treatment and condition. If the request is not approved, the referral is denied; in this event, you can request an appeal of the decision (see "If You Have a Problem").

Getting OB/GYN Care Without a Referral. Women may receive outpatient obstetrical and gynecological services directly – from a participating PacifiCare OB/GYN, family practice provider or surgeon identified by PacifiCare as providing these services – without preauthorization or PCP referral. In all cases, the doctor must be affiliated with PacifiCare; otherwise, you're financially responsible for the services. *[Reference to "(or preauthorized/referred)" deleted]*

Women may also receive all OB/GYN inpatient or hospital services, *including* emergency or urgent care, *without preauthorization* by your PCP, participating medical group or PacifiCare.

To receive OB/GYN services:

- Call the number on the back of your ID Card and request the names and phone numbers of the OB/GYNs affiliated with PacifiCare
- Schedule an appointment with your selected participating OB/GYN.

If your condition requires follow-up care, your OB/GYN contacts your PCP about your condition, recommended treatment and any women's health care services involving hospitalization.

► Accessing Care (page 65)

Generally, to receive benefits:
- You make an appointment with your PCP
- You pay a $5 office visit copay at the time you receive health care services
- Your PCP obtains preauthorization for your care as necessary
- After the copay, the plan pays 100% for most covered services and handles all forms and paperwork.

For some benefits, you may receive services from a PacifiCare network provider without PCP referral (see "Covered Expenses Under PacifiCare"):
- Chemical dependency treatment (must be preauthorized by PacifiCare Behavioral Health)
- Chiropractic care (must see a PacifiCare network provider and copay is higher when you self-refer)
- Mental health care (must be preauthorized by PacifiCare Behavioral Health)
- Urgent care
- Women's health services (such as maternity care, reproductive health services and gynecological care).

For emergency care, you may see any provider (see "Emergency Care" in the "Covered Expenses Under PacifiCare" section).

► Obtaining Preauthorization (page 66)

Generally, your PCP or specialist obtains preauthorization for services that require it through PacifiCare or your participating medical group. However, you must obtain preauthorization if you don't see or coordinate with your PCP for these services:
- Chemical dependency treatment
- Mental health care.
- *[This bullet reference deleted: "Women's health care services involving hospitalization or surgery"]*

Although you don't need preauthorization for accidents or emergencies (including detoxification), you, a family member or hospital staff member are expected to call PacifiCare or your PCP within 24 hours from the start of your care (48 hours for mental health care or chemical dependency treatment).

To obtain preauthorization for:
- Care other than mental health care and chemical dependency treatment, have your provider call PacifiCare at 1-800-932-3004 (7 a.m.-9 p.m. Pacific time, Monday-Friday)
- Mental health care or chemical dependency treatment, you or your provider must call PacifiCare Behavioral Health at 1-800-577-7244 (24 hours a day, seven days a week).

When you call for preauthorization, be prepared to give:
- Your name
- Your group number (801012 retirees, 801013 active employees or 801723 COBRA participants) and member number (on your ID card)
- The reason for your call.

If you don't obtain preauthorization as described above, your care will not be covered.

Covered Expenses Under PacifiCare

Changes to eight subsections.

► Summary of Covered Expenses (pages 67-69)

The chemical dependency treatment maximum (page 67) increases from $12,500 in 2005 to **$15,000 every 24 months** *in 2006.*

► Chemical Dependency Treatment (page 70)

The plan provides for chemical dependency treatment by an approved alcoholism or drug treatment program.

- "Medically necessary treatment of chemical dependency" is defined in the Patient Criteria for the Treatment of Substance Related Disorders II published in 1996 by the American Society of Addiction Medicine
- "Approved alcoholism or drug treatment program" is defined as any hospital or public or private treatment program that provides services for the treatment of chemical dependency, operates under the direction and control of the state and is approved by PacifiCare Behavioral Health.

No referral is required to access chemical dependency treatment, but it must by preauthorized by PacifiCare Behavioral Health and provided by a PacifiCare Behavioral Health provider to be covered (except in an emergency). Your PCP can arrange chemical dependency services or you may call PacifiCare Behavioral Health at 1-800-577-7244. *(For additional counseling and referral services, you may also call the King County Making Life Easier Program at 1-888-874-7290.)*

Chemical dependency services are provided up to the benefit maximum *as described in the summary table (see page 67)* in any consecutive 24 months. Covered services include:

- Family therapy for the patient and covered family members
- Individual and group therapy
- Inpatient care, including medical detoxification associated with acute alcohol, drug or other substance abuse
- Outpatient care
- Residential or day treatment.

In addition to the benefits listed in "Expenses Not Covered," the chemical dependency benefit does not cover:

- Confinement, treatment, services, or supplies not preauthorized by PacifiCare Behavioral Health, or supplied by a non-PacifiCare Behavioral Health provider, even if referred by the PCP, except emergency care
- Treatment for addiction to, or dependency on, tobacco, nicotine, or caffeine
- Volunteer support groups.

► Hospital Care (page 73)

Your PCP must have a preauthorization from the participating medical group or PacifiCare to receive hospital care other than emergency care.

Covered inpatient hospital care includes:

- Newborn nursery care after covered childbirth, including circumcision
- Hospital services, such as:
  - Anesthesia and related supplies administered by hospital staff
  - Artificial kidney treatment
  - Blood, blood plasma and blood derivatives
  - Drugs
  - Electrocardiograms, physiotherapy and hydrotherapy

  - Operating rooms, recovery rooms, isolation rooms and cast rooms
  - Oxygen and its administration
  - Splints, casts and dressings
  - X-ray and lab exams
  - X-ray, radium and radioactive isotope therapy
- Intensive care or coronary care units
- Physician services
- Semiprivate room, meals, general nursing care (private room charges are covered only up to the hospital's semiprivate rate, unless no semiprivate room is available)
- Surgery and anesthesia administration.

Covered outpatient hospital care includes:
- Diagnostic and therapeutic nuclear medicine in a hospital setting
- Hospital outpatient chemotherapy only for the treatment of malignancies
- Outpatient surgery
- Surgery in an ambulatory surgery center in place of inpatient hospital care.

Oral Surgery and Dental Services: Dental Treatment Anesthesia. Anesthesia and associated facility charges for dental procedures provided in a hospital or outpatient surgery center are covered when: (1) the member's clinical status or underlying medical condition requires use of an outpatient surgery center or inpatient setting for the provision of the anesthesia for a dental procedure(s) that ordinarily would not require anesthesia in a hospital or outpatient surgery center setting; and (2) one of the following criteria is met:
- *The member is under seven years of age*
- *The member is developmentally disabled, regardless of age, or*
- *The member's health is compromised and general anesthesia is medically necessary, regardless of age.*

The member's dentist must obtain preauthorization from the member's participating medical group or PacifiCare before the dental procedure is provided.

Dental anesthesia in a dental office or dental clinic is not covered. Charges for the dental procedure(s) itself, including, but not limited to, professional fees of the dentist or oral surgeon, X-ray and laboratory fees or related dental supplies provided in connection with the care, treatment, filling, removal or replacement of teeth or structures directly supporting the teeth are not covered.

► Lab, X-ray and Other Diagnostic Testing (page 74)

You must have a PCP referral to receive these benefits (remember, all must be medically necessary). Covered services include:
- Diagnosis and treatment of medical conditions of the eye by a Washington State-licensed optometrist or ophthalmologist; eyewear and routine vision exams and tests for vision sharpness are not covered under this benefit (see "Vision Care")
- Hearing tests by a physician or licensed audiologist (see "Preventive Care" for more information on routine tests)
- Lab or x-ray services, such as ultrasound, mammograms, nuclear medicine, allergy testing
- *Screening and diagnostic procedures during pregnancy as well as related genetic counseling (when medically necessary according to the standards set forth by the Washington State Board of Health for prenatal diagnosis of congenital disorders).*

► Maternity Care (page 74)

You may self-refer for women's health care services (including maternity care), *and for* inpatient hospital and outpatient surgery.

Maternity care is covered if provided by a network:
- Physician
- Licensed registered nurse midwife
- Provider licensed as a midwife by Washington State.

Covered maternity care includes:
- Pregnancy care
- Screening and diagnostic procedures during pregnancy
- Related genetic counseling when medically necessary for diagnosing congenital disorders of the unborn child
- Hospitalization and delivery, including delivery at a licensed birthing center (while preauthorization is necessary for hospital admissions, you don't need to preauthorize the length of the stay; see also "Hospital Care")
- Complications of pregnancy or delivery
- Postpartum care.

Benefits for any hospital length of stay due to childbirth for the mother or newborn cannot be limited to less than 48 hours for a vaginal delivery or less than 96 hours for a cesarean section. However, the health care provider, after consulting with the mother, may discharge the mother or newborn before the 48 or 96 hours.

The plan does not cover:
- Home pregnancy tests
- Maternity services for dependent children.

Pregnancy to Preschool. This program helps women learn how to care for themselves during pregnancies and their new babies, complimenting prenatal medical care. To enroll, contact PacifiCare (see the Resource Directory booklet).

► Mental Health Care (pages 75-77)

PacifiCare, through PacifiCare Behavioral Health (PBH), provides a team approach to mental health care, working with behavioral and medical health care providers, contracted practitioners and community resources to restore and maintain your health and productivity.

Accessing Care. You do not need PCP referral for mental health care, but you must obtain preauthorization from PBH. Call PBH directly at 1-800-577-7244 or 1-800-833-6388 (TTY), 24 hours a day, seven days a week. You'll speak with a coordinator who checks your eligibility and gathers basic information. Depending on the type of help you need, a clinician may then talk with you about what provider and treatment are best for you. If you're referred to a PBH provider, you'll be authorized for a specific number of visits for a certain time. (For information about PBH participating providers or to obtain referrals for specialty care or after-hours care, call the numbers above.)

For services outside the service area, you're covered for emergencies only.

(Counseling and referral services are also available through King County's Making Life Easier Program by calling 1-888-874-7290.)

Emergency Care. In an emergency, do everything possible to ensure your physical safety; call 911 if necessary and get to a treatment center immediately. Then, within 48 hours of admission or as soon as reasonably possible, call PBH to coordinate services after emergency treatment. This may include transferring to a provider designated by PBH when you're stable and the transfer would not create an unreasonable risk.

If you get emergency treatment from a non-network provider, you may receive a bill. Send PBH a copy as soon as possible; PBH will not pay claims submitted more than a year after the date of service. Mail bills to:

PacifiCare Customer Service Department
PO Box 31053
Laguna Hills CA 92654-1053

You're responsible for any copays or coinsurance to the non-network provider.

What's Covered. To be covered, mental health care must be provided by a hospital, physician (such as a psychiatrist, psychologist or registered nurse), residential treatment facility, provider licensed or certified by the state as a mental health counselor or a community mental health agency, or state mental hospital.

- Inpatient care – Professional and facility services for inpatient diagnosis and treatment of mental illness are covered at 100% up to 30 days per year , subject to PacifiCare Behavioral Health's preauthorization requirements and use of network providers
- Outpatient care – Outpatient services for diagnosis and treatment of mental illness are covered at $5 copay per visit to 30 visits per calendar year, subject to the preauthorization requirements and use of network providers (the average number of outpatient visits is ten or less per episode of treatment).

(Mental health care is now covered the same as other medical care, as a result of the Washington State Mental Health Parity Law, but visit limits can remain. PacifiCare's coverage for inpatient and outpatient care is consistent with requirement that mental health care be covered the same as medical care. The law, which passed in 2005, begins phasing in requirements to place mental health treatments on parity with physical health treatments on January 1, 2006.)

Covered services include:

- Diagnostic testing to determine if a mental disorder exists
- Individual and group psychotherapy
- Lab services related to the covered provider's approved treatment plan
- Marriage and family therapy
- Physical exams and intake history
- Psychological testing
- Treatment for:
  - Diagnosed eating disorders
  - Mental disorders with a congenital or physical basis, such as Tourette's Syndrome (partial coverage may be under the medical services portion of this plan)
  - Self-inflicted harm, such as a suicide attempt.

What's Not Covered. The plan does not cover:

- Certain nonorganic therapies:
  - Bioenergetic therapy
  - Confrontation therapy
  - Crystal healing therapy
  - Educational remediation
  - Guided imagery
  - Marathon therapy
  - Primal therapy
  - Rolfing
  - Sensitivity training
  - Training analysis
  - Transcendental meditation
  - Z therapy or milieu therapy

- Certain organic therapies:
  - Aversion therapy (such as electric shock for behavior modification)
  - Carbon dioxide therapy
  - Environmental ecological treatment or remedies
  - Herbal therapies
  - Hemodialysis for schizophrenia
  - L-tryptophan or vitamins
  - Narcotherapy with LSD or sedative action electrostimulation therapy
  - Vitamin or orthomolecular therapy
- Court-ordered treatment (unless determined medically necessary by PacifiCare)
- Custodial care
- Long-term, insight-oriented psychotherapies designed to regress the patient emotionally or behaviorally
- Mental retardation care
- Pathological gambling treatment
- Personal enhancement or wellness development, or related programs not considered medically necessary
- Private rooms or private duty nursing
- Spiritual counseling or dance, poetry, music or art therapy
- Substance use/abuse conditions (except as described in "Chemical Dependency Treatment")
- Surgery as treatment for a mental disorder
- Treatment for:
  - Learning disabilities
  - Mental disorders related to sexual functioning or a sex change.

Without a psychiatric diagnosis of a mental condition, the plan also doesn't cover:
- Bereavement or catastrophic illness counseling
- Biofeedback
- Counseling for adoption, custody, family planning or pregnancy
- Sex therapy or sexual addiction therapy.

Information Disclosure. What you discuss with PBH is kept confidential; PBH provides information only to the professionals delivering your treatment. However, PBH requires its contracted mental health providers to provide it with information used to coordinate your care, including:
- Name
- Date of birth
- Five Axis/DSM-IV diagnosis codes
- Description of your mental status, including symptoms and degree of functional impairment
- History of substance abuse
- Medication information
- Information on any adjunctive services being performed.

Your Rights. PacifiCare and state law establish standards to:
- Make certain you know which services are covered under this plan and any limits
- Assure the competence and professional conduct of mental health service providers
- Guarantee your right to informed consent to treatment
- Protect the privacy of your medical information.

If you:
- Have a concern about the qualifications or professional conduct of your mental health service provider, contact the Washington State Health Department at 360-236-4902
- Want more details on your mental health benefits covered under this plan, or if you have a question or concern about any aspect of your benefits, contact Pacific Behavioral Health at 1-800-577-7244 or PO Box 3009, Hillsboro OR 97123-3009

- Would like to know more about your rights under the law or believe any of these mental health benefits do not conform to the plan or your rights, contact the Washington State Insurance Commissioner at 1-800-562-6900.

► Preventive Care (page 80)

You don't need a PCP referral before seeing a network provider for routine women's health care services (maternity care, reproductive health services and gynecological care). *[Reference to "However, depending on the service (for example, if you need surgery), you may need preauthorization" deleted]*

The following preventive care is covered:
- Immunizations, including annual flu shots (immunizations for travel are not covered)
- Routine tests, such as physicals, Pap tests and hearing tests.

Mammograms are covered, but not under this preventive care benefit (see "Lab, X-ray and Other Diagnostic Testing"). Home cholesterol tests are not covered.

Preventive care benefits for children are payable according to the following schedule:

Age	Preventive Care
Birth to 1 year	Routine newborn care
1- 5 years	4 visits/year
6 - 12 years	1 visits/year

Additional Preventive Care and Health Management Programs. To help you stay healthy, PacifiCare makes these additional programs available to you (for details, contact PacifiCare; see the Resource Directory booklet):
- 24-Hour Health Information Line
- Free & Clear® StopSmoking℠
- Menopause: Understanding Your Options (online program)
- PacifiCare Perks (discounts for health and safety services/products)
- Pregnancy to Preschool (online program)
- Taking Charge of Diabetes®
- Taking Charge of Depression®
- Taking Charge of Your Health®.

Expenses Not Covered (pages 83-85)

Changes to four items in the list of services not covered (in alphabetical order):
- Acupressurist or homeopath procedures or those supplied by a Christian Science practitioner/sanitarium or rabbi *[Reference to "Acupressurist or" deleted]*
- Child's pregnancy *or termination of pregnancy [Reference to complications deleted]*
- Enteral therapy or nutritional supplements *[Reference to "enteral therapy or" deleted]*
- Obesity procedures such as weight control programs, surgery *(including bariatric)* and its complications or wiring of the jaw

If You Have a Problem

Changes to one subsection.

► Appealing Claims or Treatment Preauthorization Requests Denied for Reasons Other Than Eligibility (page 87)

If a properly filed claim or treatment preauthorization request is denied in whole or in part, PacifiCare notifies you and your provider with an explanation in writing. When a claim/request is denied for any reason other than eligibility, follow the steps described in this section. However, when a claim/request is denied for eligibility reasons, follow the steps described in "Appealing Claims or Treatment Preauthorization Requests Denied Due to Eligibility."

If you or your representative disagrees with a claim/request denial, you may try to resolve any misunderstanding by calling PacifiCare and providing more information (see the Resource Directory booklet). If you'd rather communicate in writing or the issue isn't resolved with a call, you may submit an appeal either orally or in writing by contacting PacifiCare within 180 calendar days of receiving an initial claims/request determination.

You may submit written comments, documents, records and any other information relating to your appeal regardless of whether this information was submitted or considered in the initial claims/request determination. You may obtain, upon request and free of charge, copies of all documents, records and other information relevant to your appeal.

Your appeal is reviewed by an individual who is neither the individual who made the initial claims/request determination nor the subordinate of that person. If the appeal involves a clinical issue, the necessity of treatment or the type of treatment or level of care proposed or used, the appeal determination is made by a medical reviewer health care professional who has the necessary education, training and relevant expertise in the field of medicine to evaluate the specific clinical issues that serve as the basis of your appeal.

PacifiCare reviews your appeal within a reasonable time appropriate to the medical circumstances and makes a determination within 30 calendar days of receiving the appeal. For appeals involving the delay, denial or modification of health care services, PacifiCare's written response:

- Includes the specific reason for the decision
- Describes the criteria, guidelines or benefit provision on which the denial was based
- Explains that, upon request, you may obtain a copy of the actual benefit provision, guideline protocol or other similar criterion on which the denial is based.

If your appeal involves an imminent and serious threat to your health (including, but not limited to, severe pain or the potential loss of life, limb or major body function) it is immediately referred to PacifiCare's clinical review personnel. PacifiCare immediately informs you of your review status in a written statement of the disposition or pending status of the expedited review no later than three calendar days from receiving your appeal.

Experimental or Investigational Treatment. *The Company's Medical Director may deny a treatment if he or she determines it is Experimental or Investigational. Covered Persons may request that the Company hold a conference within 20 working days of receiving the request to review the denial. The Company will respond in writing within twenty (20) working days of receipt of the fully documented appeal request.*

Non-Binding Arbitration. You have the right to submit to arbitration under the commercial mediation rules of the Judicial Arbitration and Mediation Systems. There is no charge for this service; however, the decision is not binding to either party. To initiate this, contact PacifiCare.

Coordination of Benefits

Changes to one subsection.

► Coordination of Benefits Between Plans (page 85)

If you or your dependents are covered under another health plan, PacifiCare coordinates benefits with the other plan so you receive up to but not more than 100% of covered expenses; the benefit paid by PacifiCare will not exceed the amount that would have been paid if no other plan was involved.

If another plan does not have a coordination of benefit (COB) provision, the other plan always pays first (the plan that pays first is always called primary). Otherwise, the plan that covers the individual as an employee pays before the plan that covers the individual as a dependent.

The following guidelines determine what plan pays first for dependent children covered under two parents ("parents" in this case may not be blood related, but providing coverage through a marriage or domestic partnership):

- The plan of the parent whose birthday is first in the calendar year pays for covered children first unless the parents are divorced or legally separated. (If the other plan does not have this rule, its provisions apply.)
- For a dependent child whose parents are divorced or legally separated, the plans pay benefits in this order (unless there is a court decree establishing financial responsibility for the child's health care):
  - The plan of the parent with custody
  - The plan of the spouse of the parent with custody
  - The plan of the parent without custody
  - The plan of the spouse of the parent without custody.

If a court decree establishes financial responsibility for the child's health care, the plan of the parent with that responsibility pays first.

If these provisions don't apply, the plan that has covered the employee longer pays first. Nevertheless, if either parent is retired, laid off or a family member of a retired or laid-off person, the plan of the person actively employed pays first (unless the other plan doesn't have a provision regarding retired or laid-off employees).

The plans have the right to obtain and release data as needed to administer this COB provision.

Allowable expense. "Allowable expense" means a health care service or expense (including deductibles, copayments/coinsurance) that is covered at least in part by any of the plans covering the person. When a plan provides benefits in the form of services, (for example, an HMO) the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the plans is not an allowable expense. The following are examples of expenses or services that are not allowable expenses:

1. *If a covered person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room (unless the patient's stay in a private hospital room is medically necessary or a semi-private room is not available) is not an allowable expense.*
2. *If a person is covered by two or more plans that compute their benefit payments on the basis of usual and customary charges, any amount in excess of the highest of the usual and customary charges for a specific benefit is not an allowable expense.*
3. *If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.*
4. *If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangements shall be the allowable expense for all plans.*
5. *The amount a benefit is reduced by the primary plan because a covered person does not comply with the plan*

provisions. Examples of these provisions are precertification of admissions and preferred provider arrangements.

Plan. A "plan" is any of the following that provides benefits or services for medical care or dental care or treatment.

1. *"Plan" includes: group insurance, closed panel (HMO, POS, PPO or EPO) coverage or other forms of group or group-type coverage (whether fully insured or self-insured); hospital indemnity benefits in excess of $200 per day; medical care components of group long-term care contracts, such as skilled nursing care; or other governmental benefits, as permitted by law (Medicare is not included as a "plan" as defined here; however, PacifiCare does coordinate benefits with Medicare.) For more information about Medicare, please contact PacifiCare (see Resource Directory).*
2. *"Plan" does not include: non-group coverage of any type, including, but not limited to, individual or family insurance; amounts of hospital indemnity insurance of $200 or less per day; school accident-type coverage; benefits for nonmedical components of group long-term care policies; Medicare supplement policies, a state-plan under Medicaid; and coverage under other governmental plans, unless permitted by law.*

Each contract for coverage under (1) above is a separate plan. However, if the same carrier provides coverage to members of a group under more than one group contract, each of which provide for different types of coverage (for example, one covering dental services and one covering medical services), the separate contracts are considered parts of the same plan and there is no coordination of benefits among those separate contracts. However, if a plan has two parts and coordination of benefits rules apply only to one of the two, each of the parts is treated as a separate plan.

Booklet 4

Group Health Medical/Vision

Additional information in one subsection, and a new subsection added at the end.

► Out-of-Area Coverage (page 96)

Out-of-area benefits are limited under this plan.

Emergency and Urgent Care. Emergency and urgent care are covered while traveling anywhere in the world. If you receive care from a Group Health Cooperative or Group Health-associated Kaiser Permanente provider, coverage is the same as when you see your regular Group Health provider. If you receive care from a provider not associated with Group Health, you or a family member must call 1-888-457-9516 within 24 hours or as soon as possible to receive the same coverage. (If you're unsure about when emergency and urgent care are covered, call the Group Health consulting nurse at 1-800-297-6877.)

Routine Care. Routine care is covered while temporarily living away from home for less than 90 days or living away from home as a student if received from a Group Health-associated Kaiser Permanente provider. Call 1-888-457-9516 to arrange the care.

If you retire and continue to live in Washington – even if you move out of the Group Health service area – you may continue to be covered by Group Health under the following conditions:

- *All services, except emergencies, must be provided by a Group Health provider or contracted provider.*
- *Emergency services are available outside the Group Health network, but they are subject to the increased emergency room payments. Emergency admissions must be reported within 24 hours or as soon as reasonably possible (phone numbers for reporting emergency admission to a hospital are on the back of your Group Health card).*
- *If you reside in an area served by Kaiser Permanente, you will not be able to access care through the Kaiser network. Group Health's reciprocity agreement with Kaiser only covers members on short-term travel.*

[This change has been added to clarify how your benefits are administered.]

► *Special Services (page 69)*

This subsection added to provide information about existing services not previously mentioned in Your King County Benefits and the Summary of Material Modifications.

In addition to your health benefits, Group Health offers several other services that you can use to manage your health and the health of your family.

Consulting Nurse Line. You can talk to a registered nurse 24 hours a day to get information on a variety of health and wellness topics, including advice on when to seek emergency care, at 1-800-297-6877.

Living Well with Chronic Diseases. Through this service, you can learn skills for managing your chronic conditions (such as arthritis, stroke, heart disease, chronic pain and diabetes), manage pain and medications, get help with emotional challenges, design an exercise program, manage stress, improve your quality of life and get help working with your health care team. You can access this service by logging onto MyGroupHealth at www.ghc.org or by calling 1-800-992-2279.

Covered Expenses Under Group Health

Changes to six subsections.

► Summary of Covered Expenses (pages 97-99)

There are several changes to benefits described in the summary table:

- **Alternative care (page 98) – Self-referrals to a network provider are covered up to 8 visits/medical diagnosis/calendar year for acupuncture and up to 3 visits/medical diagnosis/calendar year for naturopathy; with the exception of chiropractic services, all other alternative care may require PCP referral; all services are subject to the $20 copay/visit**
- *Ambulance services (page 98) – 80% for emergency ground/air transport; 80% for non-emergency ground/air interfacility transfers except hospital-to-hospital ground transfers (hospital-to-hospital ground transfers covered at 100%)*
- *Chemical dependency (page 98) – Maximum increases from $12,500 in 2005 to **$13,000** in 2006*
- *Manipulative therapy (including chiropractic services) (page 98) – 100% after $7 copay/visit [10 visits/year deleted]*
- *Mental health care (page 98) – **100%** up to 12 days/year for inpatient; $100% after **$7** copay/individual, family or couple visit or **$7** copay/group session for outpatient; up to 20 outpatient visits/year*
- *Neurodevelopmental therapy (page 98) – 100% for inpatient services up to 60 days/year (combined with rehabilitative services); 100% after $7 copay/visit for outpatient up to 60 visits/year (combined with rehabilitative services)*
- *Rehabilitative Services (page 99) – 100% for inpatient services up to 60 days/year (combined with neurodevelopmental therapy); 100% after $7 copay/visit for outpatient services up to 60 visits/year (combined with neurodevelopmental therapy).*

► Alternative Care (page 99)

Covered services, when medically necessary, include:

- Acupuncture, covered up to **eight** visits per medical diagnosis in a calendar year
- *Chiropractic [limit of 10 visits per year deleted]*
- Home births (see any Group Health network midwife for covered prenatal and home birth services)
- Massage therapy, as part of a formal rehabilitation program
- Naturopathy, covered up to **three** visits per medical diagnosis in a calendar year.

You can self-refer for acupuncture, chiropractic and naturopathy care but network provider referral is required for home births and massage therapy.

► Chemical Dependency Treatment (page 100)

Your PCP can arrange chemical dependency services, or for outpatient care, you may call Group Health Behavioral Health at 1-888-287-2680. *(For additional counseling and referral services, you may also call the King County Making Life Easier Program at 1-888-874-7290.)*

Treatment may include the following inpatient or outpatient services:

- Covered prescription drugs and medicines
- Diagnostic evaluation and education
- Organized individual and group counseling.

Detoxification services are covered as any other medical condition and are not subject to the chemical dependency limit. (Chemical dependency means a physiological and/or psychological dependency on a controlled substance

and/or alcohol, where your health is substantially impaired or endangered, or your ability to function socially or to work is substantially disrupted.)

► Devices, Equipment and Supplies (page 100)

Durable medical equipment is covered if:
- Designed for prolonged use
- It has a specific therapeutic purpose in treating your illness or injury
- Prescribed by your Group Health provider and part of the Group Health formulary, and
- Primarily and customarily used only for medical purposes.

Covered items include:
- Artificial limbs or eyes (including implant lenses prescribed by a network provider and required as a result of cataract surgery or to replace a missing portion of the eye)
- Diabetic equipment for home testing and insulin administration not covered under the prescription benefit (excluding batteries)
- External breast prosthesis and bra following mastectomy; one external breast prosthesis is available every two years (per diseased breast) and two post-mastectomy bras are available every six months (up to four in any consecutive 12 months)
- Non-prosthetic orthopedic appliances attached to an impaired body segment; these appliances must protect the body segment or aid in restoring or improving its function
- *Orthopedic appliances*
- Ostomy supplies
- Oxygen and equipment for its administration
- *Prosthetic devices*
- Purchase of nasal CPAP devices and initial purchase of associated supplies *(Group Health provides a referral; you must rent the device for two months before it may be purchased; you pay 20% of the rental and purchase cost)*
- Rental or purchase (decided by the plan) of durable medical equipment such as wheelchairs, hospital beds and respiratory equipment (combined rental fees may not exceed full purchase price)
- Splints, crutches, trusses or braces.

► Mental Health Care (page 104)

Inpatient and outpatient mental health services are covered. These services place priority on restoring social and occupational functioning; they include:
- Consultations
- Crisis intervention
- Evaluation
- Intermittent care
- Managed psychotherapy
- Psychological testing.

Your PCP can arrange for mental health services or you can contact Group Health Behavioral Health directly by calling 1-888-287-2680. (Counseling and referral services are also available through King County's Making Life Easier Program by calling 1-888-874-7290.)

The following mental health services are not covered:
- Custodial care
- Day treatment
- Specialty programs for mental health therapy not specifically authorized and approved by Group Health
- Treatment of personality disorders or learning, communication or motor skills disorders
- Treatment of sexual disorders, personal growth or relationship enhancement.

Mental health care is now covered the same as other outpatient medical care, as a result of the Washington State Mental Health Parity Law, but visit limits can remain. Beginning January 1, 2006, the copay for outpatient mental health care will become $7 per individual session (instead of $20 per individual session) and $7 per group session (instead of $10 per individual session), with a limit to 20 outpatient visits per year. Coverage of inpatient mental health care will change from 80% to 100%, with a limit to 12 days per year. The law, which passed in 2005, begins phasing in requirements to place mental health treatments on parity with physical health treatments on January 1, 2006.

► Smoking Cessation (page 106)

You do not need a PCP referral before you see a network provider for these services.

Covered services related to tobacco cessation are limited to:

- One course of nicotine replacement therapy a year if you're actively participating in *a Group Health-designated tobacco cessation program*
- Educational materials
- *Participation in one program a year from a network provider*.

Expenses Not Covered (page 108)

Addition of one exclusion (in alphabetical order).

- *Services covered by the national health plan of any other country.*

Coordination of Benefits

Changes in this subsection have been added to clarify how your benefits are administered.

► Coordination of Benefits between Plans (page 109)

If you and a spouse/domestic partner both have your own Group Health coverage and cover each other, your copays are waived; your children's copays are also waived if you and your spouse/domestic partner both cover your children. Otherwise, if you and a spouse/domestic partner have coverage through different plans (in other words, one plan is not Group Health), the King County Group Health plan coordinates benefits under its standard coordination of benefits (COB) policy between primary and secondary plans. If Group Health is primary, it pays first; if it is secondary, it pays up to an amount equal to the difference between the total charge and what the primary plan paid (the exact amount depends on a calculation of COB savings to Group Health).

While the plan covering an individual as an employee is primary and pays first, the following guidelines determine what plan is primary for dependent children covered under two parents with different medical plans ("parents" in this case may not be blood related, but providing coverage through a marriage or domestic partnership):

- The plan of the parent whose birthday is first in the calendar year pays for covered children first unless the parents are divorced or legally separated. (If the other plan does not have this rule, its provisions apply.)
- *If the parents are divorced or legally separated, these rules apply:*
  - *If a court decree establishes financial responsibility for the child's health care, the plan of the parent with that responsibility pays first.*
  - *If there is no court decree, the plan of the parent with custody (or primary residential placement) pays before the plan of the parent without custody.*
  - *If the parent with custody has remarried, the plan that covers the child is determined in this order: plan of the parent with custody, plan of the spouse of the parent with custody, plan of the parent without custody, plan of the spouse of the parent without custody.*

If these provisions don't apply, the plan that has covered the employee longer pays first. Nevertheless, if either parent is retired, laid off or a *spouse/domestic partner* of a retired or laid-off person, the plan of the person actively employed pays first (unless the other plan doesn't have a provision regarding retired or laid-off employees).

The plans have the right to obtain and release data as needed to administer these coordination of benefit procedures.

Booklet 5

Washington Dental Service

Covered Expenses Under WDS

Changes to one subsection.

► Basic Services (page 121)

The second bullet in the list of covered services, General anesthesia/intravenous sedation, changes to:

- General anesthesia/intravenous sedation is covered (but not both) if administered in the same day:
  - *If administered by a licensed dentist or other WDS-approved licensed professional who meets the state Dental Quality Assurance Commission guidelines in conjunction with certain covered endodontic, periodontal and oral surgical procedures as determined by WDS or as determined by the state in which the services are rendered*
  - *When medically necessary, for children through age six, or a physically or developmentally disabled person, when in conjunction with covered dental procedures*

Coordination of Benefits Between Plans (page 124)

Changes in this section have been added to clarify how your benefits are administered.

King County plans coordinate benefits under a non-duplication policy between primary and secondary plans. That means if a plan is primary, it pays first; if it is secondary, it pays only the difference between what the primary plan paid and what the secondary plan would have paid if it was primary.

If you and a *spouse/domestic partner* both have your own health coverage (medical, dental and vision) and you cover each other as dependents under your plans, your own plans are primary for each of you and secondary for each other. *This non-duplication policy applies to you and your spouse/domestic partner if:*

- *You are both county employees and insured by county plans*
- *You are a county employee and your spouse/domestic partner has coverage through another employer or a self-insured policy.*

While the plan covering an individual as an employee is primary and pays first, the following guidelines determine what plan is primary for dependent children covered under two parents ("parents" in this case may not be blood related, but providing coverage through a marriage or domestic partnership):

- The plan of the parent whose birthday is first in the calendar year pays for covered children first unless the parents are divorced or legally separated. (If the other plan does not have this rule, its provisions apply.)

- *If the parents are divorced or legally separated, these rules apply:*
  - *If a court decree establishes financial responsibility for the child's health care, the plan of the parent with that responsibility pays first*
  - *If there is no court decree, the plan of the parent with custody (or primary residential placement) pays before the plan of the parent without custody*
  - *If the parent with custody has remarried, the plan that covers the child is determined in this order: plan of the parent with custody, plan of the spouse of the parent with custody, plan of the parent without custody, plan of the spouse of the parent without custody.*

If these provisions don't apply, the plan that has covered the employee longer pays first. Nevertheless, if either parent is retired, laid off or a *spouse/domestic partner* of a retired or laid-off person, the plan of the person actively employed pays first (unless the other plan doesn't have a provision regarding retired or laid-off employees).

The plans have the right to obtain and release data as needed to administer these coordination of benefit procedures.

Booklet 7

CIGNA[1] Accidental Death and Dismemberment Insurance

Additional Benefits and Services

► Seatbelt/Airbag Benefit (page 144)

This plan pays *10% of the principal sum subject to a minimum benefit of $1,000 and a maximum benefit of $6,000* if a seatbelt fails to protect you. The accident causing death must occur while you're operating or riding as a passenger in an automobile and wearing a properly fastened, original, factory-installed seatbelt.

The plan pays an additional *5% of the principal sum subject to a maximum benefit of $6,000* if a seatbelt benefit is payable and you're positioned in a seat protected by a properly functioning, original, factory-installed supplemental restraint system that inflates on impact (an airbag).

Verification of actual seatbelt use at the time of accident and airbag inflation at impact must be part of an official accident report or be certified, in writing, by the investigating officer.

[1] *CIGNA Group Insurance products and services are provided by underwriting subsidiaries of CIGNA Corporation, including Life Insurance Company of North America. "CIGNA" is used to refer to these subsidiaries and is a registered service mark.*

Booklet 8

Flexible Spending Accounts

Throughout the Booklet

The provider for Flexible Spending Accounts (also called Personal Choice Accounts) remains the same, but the provider name changes from Associated Administrators, Inc. (AAI) to Personal Choice Account offered by Regence BlueCross and BlueShield of Oregon, referenced as PCA. (4 references).

Dependent Care FSAs

Changes to one subsection.

► Dependent Eligibility (page 158)

Eligible dependents for this plan include children, spouse, and dependent parents:

- A child under age 13 with whom you have *a "specified relationship"* and for whom you are entitled to claim a deduction on your federal tax return. For children of divorced or separated parents, the parent *with whom the child resides for more than half of the calendar year can claim* the child an eligible dependent under this plan.
- Incapacitated parent residing in your household *for more than half of the calendar year*
- Your child of any age who is physically or mentally unable to care for him/herself *and who resides with you for more than half of the calendar year*
- Your spouse who is physically or mentally unable to care for him/herself *and who resides with you for more than half of the calendar year.*

A qualifying "specified relationship" to the taxpayer for a child under 13 is defined as a son, daughter, stepson, stepdaughter, brother, sister, stepbrother, stepsister or a descendant of any such individual. Legally adopted children and foster children are considered as children of the taxpayer.

Under the Working Families Tax Relief Act, you are no longer required to provide more than one-half of the cost of maintaining your household for your dependents to be eligible for Dependent Care FSA expenses. This change became effective January 1, 2005.

Booklet 10

Glossary

Throughout the Booklet

The administrator of COBRA and the provider for Flexible Spending Accounts (also called Personal Choice Accounts) remains the same, but the name changes from Associated Administrators, Inc. (AAI) to Personal Choice Account offered by Regence BlueCross and BlueShield of Oregon, referenced as PCA. (one reference).

Booklet 11

Resource Directory

Resource Directory *(page 177)*

The administrator of COBRA and the provider for Flexible Spending Accounts (also called Personal Choice Accounts) remains the same, but the name changes from Associated Administrators, Inc. (AAI) to Personal Choice Account offered by Regence BlueCross and BlueShield of Oregon, referenced as PCA. (two references).